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ABSTRACT

The problem of mentally ill offenders is discussed in this report. Mentally ill offenders are described as generally not violent, with their behavior resulting in charges such as shoplifting, vagrancy, and trespassing. Factors increasing the number of mentally ill offenders are discussed, including the inability of families and communities to handle the deinstitutionalized mentally ill population. Problems the mentally ill face in incarceration without mental health care are also presented. Seven guidelines for improving the status of the mentally ill offender are presented, including increasing the number of psychologists and psychiatrists working in prisons and studying creative funding measures. Specific state laws impacting the mentally ill offender are presented. Five local exemplary programs are summarized. In a discussion of future trends and implications, it is noted that jails are bearing the burden of deinstitutionalization. Suggestions for system improvement such as conservatorship and mental health/law enforcement personnel linkages are made. A case study of Michigan is presented. Sixteen references are listed. (ABL)

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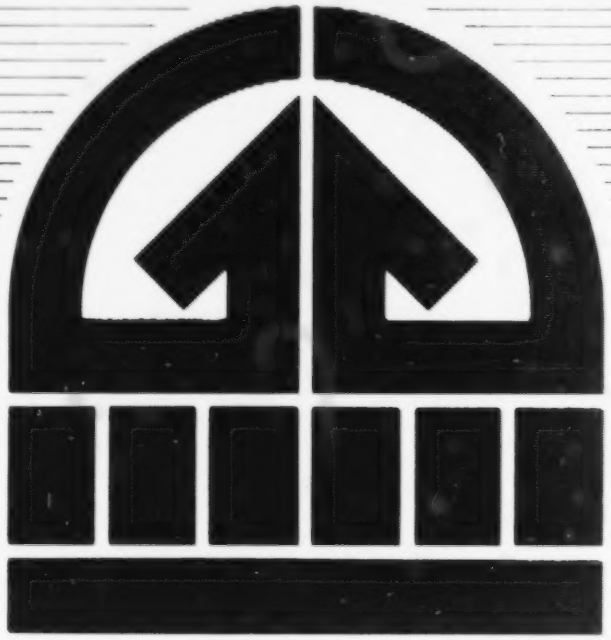

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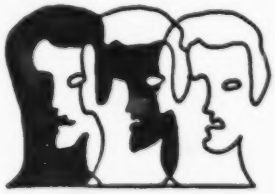

MENTAL HEALTH PROJECT

Human Resources Series

THE MENTALLY ILL OFFENDER: PUNISHMENT OR TREATMENT?

by

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NCSL Mental Health Project

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THE MENTALLY ILL OFFENDER: PUNISHMENT OR TREATMENT?

- Anne, a 50-year-old divorced woman, was arrested on a charge of trespassing. She had entered a fast-food restaurant when it opened and remained until closing time. She returned the next morning and was arrested when she refused to leave at the request of restaurant management. Anne had a long history of psychiatric hospitalizations spanning the past twenty years. Her most recent hospitalization occurred two months before her arrest, and when she returned to her apartment after being released, the manager evicted her. It was at this point that she went to the restaurant, seemingly waiting for someone to see her plight and help her (1, p. 366).

- David, a 23-year-old man with an extensive history of hospitalizations, was arrested for breaking and entering into a friend's home for undetermined reasons. Placed on probation, he was released to a halfway house. However, he was put out of the house because of inappropriate behavior. He then began carrying around a dead mouse and was repeatedly kicked out of hotels because of the smell. Still carrying his mouse, he wandered the streets giving away his money, and was regularly arrested for loitering and trespassing (2, p. 71).

- After 14 years in state mental institutions, 58-year-old Helen was discharged back to her small-town community where she shared an apartment with her elderly sister. Within one year of her hospital discharge, she had been jailed seven times on such minor charges as disorderly conduct, trespassing and creating a public nuisance. According to the local sheriff, her sister was unable to control her, the mental hospital would not take her back and "there is no where else to put her" (3, p. 7).

These individuals have more in common than their mental illness: they have been repeatedly mishandled by community systems which are unable to meet their needs for structure, control and appropriate treatment. Similar cases can be found in nearly every locality across the country. These are the people who make up the ranks of the chronically mentally ill offenders.

THE MENTALLY ILL OFFENDER: CAUGHT BETWEEN THE CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS

The term "mentally ill offender" denotes individuals who enter the criminal justice system for widely varying reasons or offenses. While the vast majority of mentally ill offenders are not violent, their illness often manifests itself in ways that society finds unacceptable. They are generally arrested and incarcerated on such misdemeanor charges as disturbing the peace, shoplifting, vagrancy or trespassing. The term mentally ill offender also may describe those persons convicted of felony crimes that have been adjudicated guilty but mentally ill (GBMI) or those who become mentally ill while incarcerated. Many mentally ill offenders fall somewhere between these two ends of the spectrum.

Factors influencing the increasing number of mentally ill offenders. Two interrelated changes in the philosophy of the nation's mental health system have contributed to the emerging problem of the mentally ill offender. The deinstitutionalization movement of the 1950s and 60s encouraged the release of thousands of mentally ill individuals from state hospitals to receive treatment at community mental health centers instead. Unfortunately, many community mental health programs were not adequately equipped to handle either the severity of the clients' illnesses or the numbers of mentally ill seeking community care. In addition,

restrictive civil commitment laws followed on the heels of deinstitutionalization, making it more difficult to involuntarily commit a mentally ill person. In most states, "dangerousness" is the primary criterion for involuntary commitment, although "gravely disabled" is often an alternate criterion. Obtaining commitment on these grounds often proves difficult, if not impossible.

Although such restrictive criteria was enacted to protect the rights of mentally ill persons, oftentimes the mental health system prevents the mentally disabled from receiving needed treatment. If family and friends cannot get their mentally ill person treated because his behavior does not fit the narrow civil commitment criteria, they may have little choice but to request police intervention. One study of a suburban police department's archives indicated that "families, friends, and others in the community call on the police to act as agents of social control for mentally ill individuals whose behavior, although disruptive, does not meet criteria for civil commitment" (4, p. 976). Because the criminal justice system is "the system that can't say no," the mentally ill individual may be jailed as a criminal for lack of a more appropriate alternative.

Critics have charged that the result of deinstitutionalization policies and restrictive civil commitment laws has been the criminalization of the mentally ill. Just how pervasive is the incidence of mental illness in the nation's jails and prisons? Unfortunately, a definite answer is difficult due to a lack of statistics, but it appears that greater proportions of the mentally ill are found in jails than in prisons (5, p. 20). One source estimates that, out of 6.2 million incarcerated in county and city jails each year, 600,000 of these are mentally ill (3, p. 1). In large cities, however, between 20 and 35 percent of jail inmates are estimated to be mentally ill (6, p. 1). Corrections officials calculate that 10 to 35 percent of state and federal prison inmates are seriously mentally ill (5, p. 19).

Although statistics are few, nearly all law enforcement personnel agree that the number of incidents involving mentally ill persons which require police attention has increased during the past 10 to 15 years. One study on the occurrence of such incidents in a suburban Pennsylvania community showed a 227.6 percent increase from 1975 to 1979 (4, p. 973). The mentally ill are also arrested 20 percent more often than non-mentally ill persons (7, p. 24), in part because their behavior makes them highly visible and because the illness may escalate a confrontation with police. Even if police prefer not to make an arrest, they may have no choice if mental health facilities refuse to accept the individual.

The general shortage of resources within mental health systems may pressure practitioners to turn away individuals brought to hospitals or clinics by the police. In some states, resources are so scarce that a patient must be released from the state hospital system before additional patients can be admitted. Emergency room psychiatrists faced with overcrowding and understaffing may try to avoid admission, or they may simply disagree with the police officer's evaluation of the person's mental condition. In addition, some experts have identified a philosophical mindset among mental health professionals who do not want to treat or experience difficulties effectively treating "acting-out" offenders (8, p. 1). Faced with such odds, many police officers find it simpler to arrest the individual, thereby ensuring that he is off the streets receiving custodial care, however inappropriate.

Incarceration of the mentally ill. Once arrested, incarceration is likely to aggravate the condition of the mentally ill. They often cannot understand why they have been locked up, and may respond with confusion, terror or rage. They are frequently unable to comply with jail rules and procedures. If not kept separated from the general population, mentally ill offenders are commonly preyed upon by other

inmates, but if they are placed in solitary confinement for their own protection, they may deteriorate even to the point of suicide (3, pp. 3-4).

In addition to the dehumanizing experience of incarceration, jails are often unable to provide adequate mental health care to mentally ill inmates, thus further exacerbating their illness. Many jails do not have available funds to employ staff who are adequately trained to identify mental illness, much less provide emergency intervention or other appropriate treatment. A 1977 survey found that only 36 percent of those jails that house mentally ill and emotionally disturbed inmates have psychological counseling available (6, p. 2). Although metropolitan jails may have mental health resources, such facilities may be so overcrowded and understaffed that inmates suspected of mental illness may be placed on a waiting list for psychiatric evaluation and treatment. In rural settings, such treatment may be nonexistent.

Lack of communication and collaboration between mental health and corrections personnel further impairs identification and treatment of the mentally ill and increases recidivism. If the criminal justice system attempts to divert a mentally ill offender to the mental health system, they may find that community mental health providers are reluctant to accept "criminal" patients, especially ones arrested for violent acts. The mentally ill offender may be unable to cooperate with an outpatient treatment plan, or may refuse such treatment. Cases like this simply fall through the cracks between the two systems, only to reappear when the person is arrested again.

The mentally ill in prisons. Another facet of the controversy over mentally ill offenders concerns treatment of such individuals in state and federal prisons. Although experts estimate that the proportion of mentally ill inmates in prison is much less than in city and county jails, mental health treatment is nevertheless often inappropriate and in short supply. Nearly all prisons experience a chronic shortage of psychiatric staff. For example, in 1983, one state employed one part-time psychiatrist to cope with a prison population of approximately 7,200. With such a shortage of mental health personnel, individual therapy is nearly impossible. As a result, psychotropic drugs such as thorazine are often the only form of treatment available (5, p. 21).

A new development within the criminal justice arena could further complicate the situation. There are now 12 states (Alaska, Delaware, Georgia, Indiana, Illinois, Kentucky, Michigan, New Mexico, Pennsylvania, South Carolina, South Dakota and Utah) which provide for a "guilty but mentally ill" (GBMI) verdict, and the proportion of inmates with mental health problems can reasonably be expected to increase. The defendant convicted as GBMI may receive the same punishment that could be meted out to a non-mentally ill defendant, even though mental health evaluation and treatment during the term of incarceration is promised (9, pp. E1-E2). However, in general, the GBMI finding does not guarantee the mentally ill inmate any treatment beyond that available to other offenders. Thus, this additional load of prisoners in need of treatment adds further pressure to an already overloaded prison psychiatric unit.

GENERAL LEGISLATIVE GUIDELINES

As emphasis on community treatment moves into its third decade, the phenomenon of mentally ill persons incarcerated in jails and prisons continues to plague criminal justice and mental health officials alike. The issue of the mentally ill offender is complicated by many interrelated factors which defy simple remedies. However, the following suggestions are offered to improve the status of the mentally ill offender (10, pp. 58-61).

- Improve communications and encourage close coordination among corrections, mental health, social services and vocational rehabilitation departments. These systems need to communicate regularly in order to understand each department's capabilities and constraints and to promote more humane case management.

- Provide training for mental health and correctional staff. Staff in both systems need specialized instruction to enable them to properly handle the special needs of mentally ill offenders.

- Assess the number of mentally ill offenders in correctional institutions to determine the amount of resources necessary to properly care for such inmates.

- Increase the number of psychiatrists and psychologists in prisons. In most prisons, overwhelming caseloads make adequate treatment of mentally ill offenders impossible.

- Entice medical schools to incorporate training with mentally disordered offenders into their programs. Current psychiatric training does not encourage or prepare professionals to work with this population.

- Study creative funding mechanisms to maximize existing resources and identify new funding sources. Some mental health programs have incorporated revenue producing activities and other business management techniques to supplement declining public support.

- Provide sufficient funding to ensure effective community treatment services, including outpatient and residential care. More comprehensive local mental health programs would be less costly than the expense of shuttling the mentally ill between state hospitals, jails and courts.

THE STATES' RESPONSE IN RECENT YEARS

Legislation

Recent challenges to the insanity defense and outcries among the criminal justice and mental health systems have encouraged state legislators to address the needs of the mentally ill offender in a number of ways. During the 1986 session, at least 12 states considered legislation which would impact upon the laws and programs concerning mentally disturbed offenders.

Criminal procedure. A number of states, including Alabama (1982 Ala. Acts, Acts 82-887 and 82-888), Colorado (1983 Colo. Sess. Laws, Chap. 188), Idaho (1982 Idaho Sess. Laws, Chap. 368), Maryland (1984 Md. Laws, Chap. 501), North Dakota (1985 N.D. Sess. Laws, Chap. 173 and 1983 N.D. Sess. Laws, Chap. 165), Oregon (1983 Or. Laws, Chap. 800), and Texas [Tex. Penal Code Ann. § 8.01 (sub. A) (Vernon 1983)] addressed criminal procedure relating to the mentally ill offender. Alabama (Act 82-888), Colorado, Idaho, North Dakota, Oregon, and Texas abolished, narrowed or revised the definition of insanity or mental condition as a defense in criminal proceedings. Alabama (Act 82-887), Maryland and New York examined standards, conditions and procedures for commitment and release.

During the 1986 session, California (A.B. 4067), New York (1986 N.Y. Laws, Chap. 2), South Dakota (1986 S.D. Sess. Laws, Chap. 194), and Virginia (S.B. 321, carried over) considered or passed legislation which would impact upon criminal procedures

affecting the mentally ill offender. New York now allows a parole board to determine the parole of inmates serving indeterminate sentences with the mental health department. If passed, Virginia would require that, for those found not guilty by reason of insanity and found to be dangerous, placement could be made in a corrections facility under the custody of the mental health department.

Commitment. During recent years, at least four states have passed legislation concerned with the involuntary commitment of mentally ill offenders, including Arizona (1983 Ariz. Sess. Laws, Chaps. 92 and 287), Arkansas (1983 Ark. Acts, Act 917), California (1985 Cal. Stats., Chaps. 1286 and 1416), and Florida (1982 Fla. Laws, Chap 82-224). Arizona (Chap. 92) provides procedures for the involuntary commitment of prisoners found to be mentally ill to a state hospital or inpatient facility. California (Chap. 1286) provides for placement on outpatient status of persons convicted of felonies and sentenced to the state prison subject to the same procedures of mentally ill offenders committed to a state hospital. During the 1986 session, Maine (1986 Me. Laws, Chap. 630) passed legislation which required that an examination of incarcerated prisoners be made to determine if commitment to a mental health facility is needed. In an effort to treat the mentally ill before they become involved in the criminal justice system, Michigan (1986 Mich. Pub. Acts, Acts 117 and 118) has revised commitment procedures that now allow for voluntary treatment, short hospitalizations, and combined and alternative treatment orders.

Treatment. In recent years, Arizona (1984 Ariz. Sess. Laws, Chap. 92), California (1985 Cal. Stats., Chaps. 82, 1286, 1419), Florida (Fla. Laws, Chap. 82-224) and Texas (1985 Tex. Gen. Laws, Chap. 554 and SCR 128, passed 1985) passed legislation concerned with the treatment of mentally ill offenders. In part, California (Chap. 1286) established mentally ill jail inmates, mentally ill wards of juvenile detention facilities, and mentally ill persons who are nuisance offenders as priority populations for the provision of county mental health services. In addition, the new law allows a peace officer to detain and transport a mentally disordered person who is dangerous or gravely disabled to an evaluation and treatment facility. Florida now ensures that mentally ill inmates receive evaluation and appropriate treatment for their illnesses through a continuum of services. Texas (SCR 128) encourages the development of creative community-based alternatives for mentally disabled offenders.

During the 1986 session, California (1986 Cal. Stats., Chap. 43, S.B. 1704, A.B. 3132), Kentucky (1986 Ky. Acts, Chap. 155), Massachusetts (H.B. 4101), Pennsylvania (H.B. 2075), and Virginia (H.B. 749, carried over) are considering legislation which would impact upon the care and treatment of the mentally ill. California (S.B. 1704) also would establish a diversion program for the chronically mentally ill charged with misdemeanor charges. If passed, Pennsylvania would be required to provide treatment in a mental health facility for those incarcerated on criminal charges. Virginia (H.B. 749) would require the corrections department to provide mental health treatment to prisoners in need.

Rights. Several states have attempted to address the various rights of the mentally ill offender in recent years, including Arizona (1984 Ariz. Sess. Laws, Chap. 287) and Florida (1982 Fla. Laws, Chap. 82-2240 and 1986 Fla. Laws, Chap. 85-167). Arizona restricts the physician-patient privilege of confidential communication if any mental disability defense is raised in a criminal prosecution. Florida (Chap. 85-167) now provides for the rights of forensic clients, including confidentiality of clinical records, right to treatment and right of individual dignity. If passed, New York would be able to release patient records from the mental health department to the corrections department.

Studies. At least four states, California (1986 Cal. Stats., Chaps. 1416 and 1286), North Dakota (1983 N.D. Sess. Laws, Chap. 751), Tennessee (SR 21, passed, 1985), and Wisconsin (SJR 5, passed, 1985) passed legislation to conduct studies affecting mentally ill offenders. California (Chap. 1286) will fund five counties to assess with county mental health and law enforcement agencies the adequacy and appropriateness of existing county mental health emergency response systems. Calfornia (Chap. 1416) also authorized an investigation into the prevalence of severe mental disorders among state prison inmates and parolees. North Dakota directed a study on use of the insanity defense in criminal trials. Wisconsin will study problems related to the mental health services provided to prisoners. Tennessee will study proposals for the treatment and alternatives to the housing of the mentally ill in the state corrections system.

Exemplary Local Programs

In addition to legislative efforts to improve the treatment of the mentally ill offender, many states have developed and implemented model programs which are effective and efficient in working with the mentally ill offender. The following model programs provide innovative examples of collaborative efforts between the mental health and criminal justice systems and effective treatment models which successfully deal with this disabled population. Summaries for the various state approaches were largely excerpted from Removing the Chronically Mentally Ill from Jail: Case Studies of Collaboration Between Local Criminal Justice and Mental Health Systems, National Coalition for Jail Reform, March 1984 (10).

Madison Police Department and Dane County Mental Health Center, Madison, Wisconsin. Through coordination between the Madison Police Department and the Dane County Mental Health Center, the chronically mentally ill have been successfully diverted from jail in Madison. A social service coordinator position serves as the liaison between the police and social service agencies. New police recruits and veteran officers receive training in identification and crisis intervention. Police can make referrals to a 24-hour crisis intervention program if necessary. The mental health center maintains several staff in the jail to identify and treat mentally ill inmates. In addition, the two systems collaborate in providing a mobile community treatment team to treat the most difficult and treatment-resistant mentally ill persons. Funding for the program is provided by the Madison Police Department and the Dane County Mental Health Center.

Galveston County Mental Health Deputy Program, Galveston County, Texas. Initiated in 1975, the Galveston County Mental Health Deputy Program employs a team of deputies who specialize in dealing with emergency situations involving the mentally ill and emotionally disturbed. In addition to their law enforcement duties, the deputies are trained in crisis intervention and emergency medical techniques. After deputies screen and evaluate an individual, either outpatient services are arranged for those not in urgent need, or the deputy appeals for legal action in order to transfer the client to a special hospital for emergency psychiatric evaluation. Permanent on-going funding is being sought on a statewide basis from the Texas Mental Health and Mental Retardation Department and the Texas Criminal Justice Division for replication of the program in all urban county sheriff's departments within Texas.

The Mental Health Center of Boulder County Jail Program, Boulder, Colorado. Through an intensification of jail mental health services and improved availability of psychiatric inpatient services to county residents, the Boulder County Jail population suffering from psychosis has been significantly reduced. A special mental health team provides regular on-site evaluations and treatment to jail inmates, with

an emergency team providing 24-hour services for the seriously disturbed inmates. The clinical program of the mental health center evaluates mentally ill inmates, arranges the disposition of clients to appropriate treatment outside the jail when possible, provides treatment within the jail, serves as the liaison between involved nursing and corrections personnel, and provides limited training to jail personnel. The majority of psychotic offenders are transferred to treatment settings allowing for adequate psychiatric inpatient care or community support services.

San Gabriel Valley Region Mobile After Hours Crisis Intervention Program, Los Angeles County, California. Implemented in 1981, the Mobile After Hours Crisis Intervention Program provides rapid assistance in psychiatric emergency situations anywhere within the Los Angeles County community at times where traditional mental health services are not available. The mobile unit collaborates effectively with law enforcement officers in order to deter inappropriate incarceration in jail, and has helped to update crime prevention services in local communities. Clients admitted through the Mobile After Hours Crisis Intervention Program are assured of follow-through and continuity of care. The California Community Mental Health Act enables the program to be funded primarily by the state.

Monroe County Mental Health Clinic for Socio-Legal Services, Monroe County, New York. The Monroe County Mental Health Clinic was established in 1964 to meet the varied mental health service needs of the criminal justice system for the county's large urban/suburban/rural population. It provides judges and the courts with evaluations of defendants' competency to stand trial, comments on social risk and dangerousness, evaluates the need for treatment, assists with dispositional planning, as well as provides direct primary mental health care to those under the jurisdiction of the court. All inmates of the county jail, whether sentenced or unsentenced, are hospitalized immediately following a determination of need for psychiatric hospitalization. Individuals in jail requiring crisis intervention are seen immediately and county jail inmates have access to a comprehensive interdisciplinary mental health team during the work week. Funding for the clinic is dependent on funds allocated and dispersed by the Monroe County manager and the county board, but the affiliation with the University of Rochester provides professional services at little or no cost to the county.

FUTURE TRENDS AND IMPLICATIONS

In its effort to resolve deviant or disruptive problems, society has allowed today's jail to become the storage place for many mentally ill persons. In addition, many chronically mentally ill individuals are finding and police are using the criminal justice system as the last and frequently the only resort for care whether appropriate or not. The jail is now carrying the burden of deinstitutionalization policies of the past. Individuals in need of mental health care have become so prevalent in detention facilities that many consider this situation to be a priority management and treatment problem.

However, despite the protests of jail and mental health administrators about the inappropriateness of housing the mentally ill in jail, this situation seems unlikely to change in the near future. The continued detention of mentally disordered persons in the criminal justice system most likely will be prolonged by three major factors (11, p. 3):

- an unlikelihood that the policies or procedures for state mental hospitalizations will drastically change;

- society's continued intolerance of mentally disordered behavior and the use of the criminal justice system to resolve or remove the problem; and

- the continued budget reductions in mental health areas which will shift the financial burden to alternative institutions, including the jail and/or prison.

The future of the mentally disordered offender does not have to be a necessarily bleak and dismal picture. State and local governments can and have moved in many directions to greatly improve the care and treatment of the mentally disordered offender on both humanitarian and practical levels.

- Legislatures are funding commissions to develop local programs and processes between both the criminal justice and mental health systems for mentally disordered offenders.

- Localities across the country have implemented programs to divert mentally disordered offenders away from the criminal justice system into more appropriate services.

- Conservatorship is being used to provide on-going contact and monitoring for those mentally ill in need of social controls.

- Linkages between law enforcement and mental health personnel are integrating communication between systems and improving service delivery.

Given the current realities of mental health and criminal justice financing at state and federal levels, it is unlikely that the vast array of services needed by both systems will be available in the near future. In addition, some medium to large jails across the country have begun to develop in-jail acute mental health treatment units when cooperative efforts between the mental health and criminal justice system have failed. However, practical planning strategies can be developed for the provision of at least minimum mental health services and for the improvement of linkages between jails and mental health agencies. Whatever the best long-range solutions, jails will continue to incarcerate individuals needing mental health services in the foreseeable future and both the mental health and criminal justice systems must plan accordingly.

CASE STUDY: MICHIGAN

INTRODUCTION

In response to public and professional concern about the lack of adequate mental health treatment for the mentally ill in jails and the community, an ad hoc task force to the Legislative Chapter 4 Mental Health Task Force was formed in December 1983 and chaired by Representative Debbie Stabenow. The task force was mandated to address the problems of the mentally ill in county jails and the lack of appropriate support services to maintain these individuals in the community.

Based upon a survey of all Community Mental Health Boards in 1984, the task force was able to gather information about mental health services currently available to county jail residents, measure the need for additional services and assess the need for changes in state policies. It was determined that approximately 24 percent of the jail population was in need of mental health services and 87 percent of the Community Mental Health Boards indicated that new or additional mental health services were needed in the county jails (12, p. 4).

The final report of the Chapter 4 Mental Health Task Force identified areas requiring improvement and made recommendations for future action. Since that time, Michigan has been active in its efforts to improve services to the mentally ill in jails and the community.

- In 1983-1984, the Department of Mental Health funded a pilot program, the Harbinger Project in Grand Rapids, which has proved effective in diverting mentally ill individuals from repeated involuntary treatment and involvement in the criminal justice system. The Department of Mental Health is planning to replicate similar models elsewhere in the state.

- The Department of Mental Health is currently funding at least eight consumer-run demonstration programs throughout Michigan to provide outreach, advocacy and support services to the mentally ill in the community.

- The Michigan Sheriff's Association received a $200,000 grant from the Department of Mental Health to implement a two-year technical assistance project that would disseminate information about successful programs and assist cooperative local interagency efforts.

- The Department of Mental Health will match funds with the National Institute of Mental Health to provide training for jail and community mental health staff in identifying those in need of mental health services and appropriate alternatives for these persons.

- The Michigan Legislature has also attempted to expand funding for non-traditional community mental health programs and pilot projects and is currently attempting to address community and institutional treatment of the mentally ill.

To specifically address Michigan's issues and concerns regarding the mentally ill within the criminal justice system, the NCSL Mental Health Project agreed to provide the state with a technical assistance program in January 1986. Members of the House of Representatives and Senate, legislative staff, Department of Mental Health personnel, Community Mental Health Board representatives, and sheriffs provided information on the collaboration problems and efforts between the mental health and

criminal justice systems. Dr. Henry J. Steadman, director of evaluation research at the New York State Office of Mental Health, and Joseph R. Rowan, executive director of Juvenile and Criminal Justice International Inc., provided Michigan with suggestions concerning collaboration between the mental health and criminal justice systems to improve treatment of the mentally ill offender. The suggestions presented are not necessarily those of the NCSL Mental Health Project or the National Institute of Mental Health.

THE PROBLEM OF THE MENTALLY ILL IN MICHIGAN'S JAILS

Over the past few years, there has been a notable increase in the number of chronically mentally ill individuals coming into contact with the criminal justice system. The Community Mental Health Boards and the Michigan Sheriff's Association both recognize the problem of mentally ill persons lodged in jails and that a solution will require shared action and responsibility. Almost 80 percent of the sheriffs report that housing the mentally ill in jails is creating serious management problems due to their volatileness and vulnerability to more aggressive inmates (13, p. 1). Several factors complicate the effective provision of services to the mentally ill in the jail or community including (14):

- No formal standards and implementation procedures for the provision of mental health services in county jails.
- Inadequate resources to provide care for the mentally ill jail population, including mental health services, staffing levels and training.
- Limited cooperation among Community Mental Health Boards and sheriffs concerning available resources and responsibility.

Inadequate resources. For those who have been repeatedly involuntarily hospitalized and involved in the criminal justice system, there are few services available to divert this population. Non-traditional community programs including intensive case management, outreach, support and advocacy services are greatly needed. Jail personnel are hard pressed to provide the special services and confinement required by mentally ill inmates. Only 34 percent of jail staff have special training with mentally ill inmates, and understaffing, overcrowding and antiquated jail conditions create major containment and prevention problems. Over 90 percent of the Community Mental Health Boards related the need for new or additional mental health services in the jails. While counseling, 24-hour crisis, and psychiatric care are provided in over half of the jails, only 2 percent provide follow-up crisis or case managment services.

Limited cooperation. Local cooperative efforts to better serve the mentally ill who are in county jails or at risk of being jailed are desperately needed. Although many of the problems confronting the criminal justice and mental health systems can be resolved at the local level, dialogue between the two systems is sparse and largely reactive. Formal agreements and communication between the Community Mental Health Boards and sheriffs are minimal. Mental health personnel are often unfamiliar with the criminal justice system's responsibilities and resources. Jail personnel often lack the skills to identify and manage mental health problems. In addition, the two systems approach the problem of the mentally ill offender from two largely different philosophies--punishment vs. treatment. This lack of collaboration results in an ineffective mental health jail screening, treatment and/or referral system that wastes time and money.

Lack of standards. Many of the mentally ill inmates in jails do not meet the legal definition for involuntary civil commitment, forcing the jail to become the only treatment option. Diagnosis limits involuntary treatment for a large number of jailed mentally ill and the existing commitment process is not responsive to those who are resistant to traditional mental health services or require long-term treatment. Additionally, the Department of Mental Health and the sheriffs should formulate standards for the provision of mental health services in county jails.

PROMOTING EFFICIENT AND EFFECTIVE MENTAL HEALTH CARE IN JAILS

Although there is no best way to organize and develop jail mental health services, there are basic guiding principles which could be implemented. Dr. Henry Steadman has developed several basic options and strategic choices that could improve the inadequate structure that exists in many jails today (15, pp. 141-160). Through efforts within the Department of Mental Health and the Sheriffs' Association, many of the following suggestions have been implemented or are being implemented in Michigan.

The mentally disturbed jail inmate must be viewed as a community issue. Since it is impractical to consider developing a comprehensive set of mental health services within most jails, the jail must make effective use of staff expertise in a variety of community programs and should plan services in ways that can share program resources. The jail should be viewed as only one agency in a continuum of community services.

To adequately respond to these issues, a three-pronged approach could be implemented by the criminal justice and mental health systems.

- Convene a meeting of the key actors from the full range of mental health agencies in the county. Input and cooperation from these actors is needed to devise a strategy on how the jail can effectively obtain on-going mental health services in the community. Mental health and jail administrators, judiciary members and top county officials should be involved and kept advised of jail efforts to develop mental health programming.

- A needs assessment should be developed to determine what the needs are, what services were used in recent years, who delivered the services and what was the cost of services. This could be achieved through an examination of state and federal expenditures regarding the incarceration of the mentally ill and through a review of institutional records.

- Public education and involvement is required to foster an interest in the mentally ill and provide a mandate to improve correctional services and non-custodial treatment options. In various counties across the country, this has been achieved through citizen advocacy councils, task forces, and public education efforts through news conferences, press releases, school curriculum and other measures.

The jail is and should remain primarily a correctional facility. Mentally ill individuals should not be subject to incarceration unless there is substantial breakage of the law. Although advantageous in the short run, expansion of mental health care in the jail may lead to the perception that the jail is an appropriate place to send mentally ill persons who do not really have to be incarcerated. The expansion of mental health services in the jail may also lead to a transfer of resources from more appropriate community programs. State sheriffs' and police organizations should consider training efforts for their officers concerning policy

on arresting and incarcerating persons only when there has been substantial violation of the law.

There are serious mental health needs among inmates that require limited but high quality professional services in every jail. Although the jail is obviously not an ideal locale for delivering mental health services, there are clear needs that must be met. Ideally, identification upon admission should not only involve the administration of a screening instrument but also referral to mental health staff with the capacity to respond to emergency situations. Depending upon the emotional disturbance of the inmate, referral to inpatient psychiatric units or to outpatient care while administratively segregated or in the general jail population should be available. The care should be prompt and flexible, with a premium on inmate management.

In addition to core mental health services in the jail, communities should attempt to divert the mentally ill person before and after incarceration.

- Police officers and sheriffs' deputies can be specially trained to work with mentally ill people encountered in their law enforcement duties. In Virginia, a special state curriculum was developed for arresting jailers and mental health personnel who work with offenders concerning the recognition and handling of mentally ill arrestees (16).

- Other police agencies have chosen to work with mental health professionals, such as the Montgomery County Mental Health/Mental Retardation Services program in Norristown, Pennsylvania, who can respond to crisis situations as they occur through the use of on-the-scene mental health counselors and mobile crises units.

- For those counties without mobile care teams or specially trained officers, diversion efforts can be implemented while the individual is in custody but prior to sentencing. A counselor could work closely with criminal justice personnel to get charges dropped or modified, arrange a release and make appropriate referrals. The Community Corrections Department in Boulder, Colorado operates a special program that interviews and refers mentally ill prisoners for community treatment when appropriate.

Correctional administrators should concentrate their efforts on developing mental health services in the areas of identification, crisis intervention and case management at release. Jails are short-term facilities and should focus on helping inmates cope with the stresses of incarceration instead of attempting rehabilitation. Some jails employ crises counselors who are available around the clock to deal with the arrest and incarceration phenomenon, thus preventing more serious mental health situations from developing. Such services are needed that de-emphasize traditional treatment in favor of early identification, appropriate short-term interventions either through medications or specialized housing, and effective collaboration with community resources to maintain the person in the community.

This effective collaboration of resources and establishment of a continuum of care can be accomplished through a variety of measures:

- Splitting mental health staff time between the jail and community agencies to encourage continued involvement after release;

- Assigning the primary responsibility of mental health care to employees who work full-time at the county jail;

- Establishing a coordinator over both the mental health and jail programs to oversee the provision of services to mentally ill persons in the jail and community; and

- Assigning a community mental health center staff to the jail for the provision of screening and case management services or have the staff responsible for initial evaluations make appointments to see the inmate after release.

There is no best way to organize a jail mental health program. Jails of varying size, structural characteristics, perceived need levels and available resources require different strategies for organizing mental health services in the jail. To identify the optimal service structure for a jail, persons in the community who would be most appropriate to discuss jail mental health services need to be identified and programming issues need to be analyzed. Most importantly, there must be appropriate linkages between the jail and existing mental health providers in the community.

To further expand collaboration efforts between the two systems, Michigan could consider implementation of the following measures:

- Facilitating regular meetings between the two systems both at the system-wide level and at the case management level;

- Collaborating between the systems to plan and implement an improved mechanism to process and assist those with mental illness;

- Establishing a unified, accountable case management system which focuses on maintaining the mentally ill in the community, not the jail;

- Educating those affected by both systems about the responsibilities and available resources within both mental health and criminal justice systems; and

- Providing specialized training for personnel within both systems, with police and jail staff working in mental health settings and mental health personnel covering criminal justice settings.

CONCLUSION

"For many (mentally ill), one kind of institution--the mental hospital--has been replaced by another institution--the jail" (3, p.2). Crimes are often less the result of criminal intent than an inability to function in their communities. However, jail has become the only place for the mentally ill when their communities turn them away.

The criminal justice and mental health systems must determine ways of working together to meet the needs of the mentally ill incarcerated for minor offenses. Through cooperation and collaboration, the two systems can become effective in helping the mentally ill make it in the community. Michigan has already established much of the groundwork needed for the establishment of a more efficient and effective system serving the mentally ill in both the community and jail, but further action is necessary to achieve needed changes and promote progress.

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TECHNICAL ASSISTANCE BACKGROUND MATERIALS

Available through the NCSL Mental Health Project are background materials distributed at the Michigan Technical Assistance program. Background materials relating to the mentally ill offender include a summary of select state legislation, a discussion of model programs, a bibliography and a checklist that interested legislators and staff may return for copies of legislation and bibliographic materials.

If you wish to receive the background information distributed at the technical assistance program, please copy, complete and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

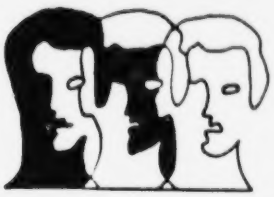
Name: _____

Title: _____

Address: _____

_____

Requesting Michigan background materials ___



MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In February 1985, the National Institute of Mental Health (NIMH), U. S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues.

The goal of the NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information surrounding mental health issues.

Through this fourteen month program, the Mental Health Project can respond to specific issue and format needs of legislators. By involving the Panel of Experts, a group composed of legislators and persons with mental health experience, expert consultants, and state policy makers, programs will be developed to provide a variety of services to states, including testimony, special workshops and seminars, and staff assistance.

Based upon input from the state legislatures, ten states were chosen to receive technical assistance with state-specific mental health issues. Along with the programs, background materials, audio tapes, and a State Legislative Report will be developed for each issue area and are available free of charge to requesting parties. The scheduled technical assistance programs include:

South Carolina	Involuntary Civil Commitment	May 10, 1985
California	Mentally Ill Homeless	August 7, 1985
Missouri	Mental Health Services Coordination	September 24, 1985
Kentucky	Mental Health Services for Adolescents	October 3-4, 1985
Pennsylvania	Revolving Door Syndrome of Mental Health Services	October 23, 1985
Virginia	Housing for the Mentally Ill	November 18, 1985
Oklahoma	Community Care for the Chronically Mentally Ill	December 4-5, 1985
New Hampshire	Mandated Mental Health Insurance/ Mental Health Services for the Elderly	January 9, 1986
Michigan	Mentally Ill Offender	January 28, 1986
Oregon	Mental Health Services Funding	March 4, 1986

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